When is conduct reportable? National Practitioner Data Bank takes complaints from hospitals about physicians

The peer review process is not black and white, which raises questions on reportability. And once a report is made, it's hard to undo the damage.

By AMY LYNN SORREL, AMNews staff. Posted Sept. 21, 2009.

In an effort to promote patient safety across state lines, the National Practitioner Data Bank was created to give hospitals a snapshot of any issues with a physician's history before credentialing. The idea behind the repository was to streamline a patchwork of state laws governing the reportability of adverse actions against a doctor's privileges.
Some medical and legal experts say the data bank can be a helpful tool to ensure patient safety. But the complexities of the peer review process continue to create uncertainty as to when competence or conduct issues are reportable, with implications for the doctor whose name ends up on such a report, experts say.

"The data bank establishes the reportability requirements, but it does not remove the role of physicians and medical staff to police themselves," said Patrick J. Hurd, a health care lawyer and partner with Virginia-based LeClairRyan.

The confidential data bank was established by the federal Health Care Quality and Improvement Act of 1986 and generally requires hospitals to report doctors whose privileges have been restricted or revoked for more than 30 days based on competence issues or professional misconduct.

"That's the basic criteria. But as to what acts or omissions cause that restriction, it really varies," said Hurd, adding that the rules leave those standards to a hospital's medical staff bylaws and practices.

In addition, there is a range of actions hospital peer review and medical executive committees can take to address quality or behavior issues that do not necessarily trigger reporting, said Stacey L. Gulick, a medical staff lawyer with Garfunkel Wild & Travis PC's Great Neck, N.Y., office. For example, a hospital may require additional training, or a retrospective review of a doctor's performance after each case, without necessarily restricting the doctor's privileges.

Gray areas

If an action is taken against a doctor's privileges, however, "sometimes it's debated as to whether it was done based on clinical competence or conduct," which could prompt a data bank report, for something else, Gulick said.

Where it also gets complicated is whether a doctor is under a formal investigation, she said. Adverse actions against a doctor's privileges typically aren't reportable until a final peer review determination is made or an investigation is complete. "But the question is at what point does an investigation begin, not at what point does it end, and that's a situation that's often disputed."

A court decision, while providing some guidance on the issue, left that question unanswered.

In January, a panel of the 1st U.S. Circuit Court of Appeals clarified that an investigation remains ongoing until the hospital's decision-making process runs its course, and the medical executive committee either takes final corrective action or formally closes the probe.

The case centered on data bank rules that require reporting if doctors resign or surrender their privileges while under investigation, which the court affirmed were intended to prevent doctors from resigning to avoid a report.

Hurd said the decision reinforces the fact that there's a continuum to the peer review process and gives review committees room to evaluate a situation before pursuing formal action. An ineffective investigation, however, can unnecessarily drag out the process and leave the physician under review "twisting in the wind," he added.

But physicians attorney Andrew B. Wachler said the ruling points up a gap in the rules that leaves doctors vulnerable to resigning without knowing that a formal investigation has begun. He also noted a lack of flexibility in data bank rules for doctors and hospitals to discuss a resolution once
an investigation is under way.

"Hospitals are forced to file a data bank report, and that forces the physician to exercise his or her appeal rights," which can lead to litigation, said Wachler, a founding partner with Wachler & Associates PC in Royal Oak, Mich. Once a report is made, "it's a mark on [the doctor's] record" and can hurt a physician's career.

**Due process concerns**

Richard Chudacoff, MD, knows what that's like. The Las Vegas-area ob-gyn is fighting to remove what he believes is an inappropriate data bank report. The U.S. District Court for the District of Nevada concluded in April that the hospital that reported him did not give him fair notice and hearing rights before suspending and ultimately firing him. The hospital involved said it acted properly.

Dr. Chudacoff said he later was denied privileges at hospitals in California and Texas because of the data bank report. "I was lucky I kept my [private] practice [in Las Vegas] open so I can still work. ... But I don't know how many patients I've lost or haven't been referred to me," he said. "The longer [the data bank report] is there, the more harm it does."

His attorney, Jacob L. Hafter, said the reporting rules leave room for hospitals to short-circuit due process "because the triggering event for reporting is not when due process is completed, but when an action has been taken. So if you get suspended, [a hospital] has to report within 30 days, regardless of whether or not the action was proper. And that has catastrophic results" for a doctor's career.

But there's nothing in a data bank report that a hospital clinical privileges application doesn't already ask for, said Robert Oshel, PhD, speaking on his own behalf. Oshel is former associate director for research and disputes in the Dept. of Health and Human Services Health Resources and Services Administration's Division of Practitioner Data Banks. HRSA manages the National Practitioner Data Bank but officials declined comment for this story.

Hospitals also are required to follow federal fair hearing and notice standards or they risk losing immunity from legal liability, Oshel said. "Whether or not [hospitals] follow the procedures doesn't impact the reporting responsibility. But it does impact greatly the ability to defend oneself if a physician sues an entity for taking action."

Doctors also have recourse through the HHS secretary for voiding a report that should not have been filed, or for amending the content of an erroneous report, Oshel added.

But New York attorney Gulick said challenging a data bank report is no easy task. If a hospital refuses to withdraw or modify a report, physicians can file a dispute based on the factual accuracy of a report or a procedural violation. But the data bank will not get weigh in on whether the doctor deserved to be sanctioned.

American Medical Association policy generally supports creating other physician quality tracking mechanisms as alternatives to the National Practitioner Data Bank, which also includes information on medical board discipline and liability payments. Meanwhile, the AMA advocates for accurate reporting to the federal repository, as well as proper due process and notification to physicians before a report is filed.

Still, other observers suggest hospitals avoid reporting requirements by failing to discipline physicians adequately in the first place.

The database has received an average of 650 reports per year from 1990, when it began, to 2007,
according to the consumer group Public Citizen, which analyzed studies from HRSA and the HHS Office of Inspector General, as well as medical journal articles.

The group, in its May report, found that as of 2007, nearly half of hospitals nationwide had never filed a report. Its study suggested hospitals are using "loopholes" in federal regulations to evade reporting, for example by disciplining doctors for less than 30 days or granting a leave of absence instead of a suspension.

Also playing a role is hospitals' fear of being sued or losing business if a doctor is let go, said Alan Levine, a health services researcher with Public Citizen and lead study author. He acknowledged the peer review process is not "black and white."

Nevertheless, Levine said, "the bottom line is federal law is there for a reason, and the public deserves to have those laws followed. ... We'd like to trust that quality improvement is going on for patients, but at the same time, there has to be some accountability."

Hospital executives say the data bank can be a helpful tool in quality assurance, but not the only one. "There is a whole series of remedies hospitals can take, and many of those actions are not reportable," said Brian H. Fillipo, MD, Connecticut Hospital Assn. vice president of quality and patient safety. The state had a lower rate of nonreporting than others, with 25% of hospitals not filing a report, according to Public Citizen's analysis of NPDB data.

"The data bank was really intended to identify egregious cases, and [hospitals] are doing that. ... It's not going to benefit the patients, hospital or medical staff to have an incompetent physician keep practicing," Dr. Fillipo said.

South Dakota had the highest rate of nonreporting, with 75% of hospitals not filing any reports. But Dave Hewitt, president and CEO of the South Dakota Assn. of Healthcare Organizations, said there is no correlation between those numbers and quality, noting that the state still stands above the national average in federal quality rankings.

"Effective recruitment and retention are essential for South Dakota hospitals, so much of the work on finding the right practitioners is done preemptively on the front-end," he said in a statement.

Virginia attorney Hurd said some underreporting is likely because of the weight a data bank report can carry. But for the most part, hospitals and peer review committees are doing their jobs, he said, adding that a recent push for quality improvement likely has influenced what may appear to be low reporting.

Hurd said medical staffs should be mindful of their reporting obligations, but designing their peer review programs around reporting diminishes their effectiveness.

The bylaws can help establish a framework for addressing complaints and investigations, "but you can't anticipate every situation and make them so cumbersome you handcuff the physicians," he said.

"Having a robust program in place to address peer review and non-peer review issues overall, and maximizing its value, whether or not an issue rises to the level of a data bank report, is what's important," Hurd said.

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Undoing the damage

Reversing a National Practitioner Data Bank report is no small task, experts say. But physicians do have some recourse.

- Notifications are mailed to physicians once a report is submitted to the data bank, so reports should be reviewed immediately; doctors may request a copy.
- Data bank reports are published as submitted by the reporting entity. To minimize potential disputes, those entities should consult with the doctor under review before submitting a report.
- If the information published in a report is inaccurate, doctors first must contact the reporting entity to request a correction. If the reporting entity declines, the physician may petition the data bank to append a personal statement clarifying the report.
- Doctors also can appeal to the data bank on whether the report was properly submitted according to federal requirements. If the reporting entity does not correct or void the report, or fails to act, doctors can petition the secretary of the Dept. of Health and Human Services for further review.

Sources: Dept. of Health and Human Services, Health Resources and Services Administration, American Medical Association